Nevada Medicaid: 1915(i) Waiver Service Plan

Date of Assessment:
Name of Assessor:

1. Recipient Information					
Last Name:		First Name:			
Medicaid Number:		Date of birth:			
Translator required: ☐ Yes ☐ No		Language:			
Address:					
City:	State: NV	Zip code:	Phone		
☐ Male ☐ Female	Age:				

2. Designated Representative/Legal Guardian (if applicable)			
Designated Rep. name:		Phone:	
Does Designated Rep. reside in the home?	☐ Yes ☐ No	Relations to recipient:	

3. Emergency contact information Complete this section if recipient has no LRI (such as POA, family member, personal care representative)			
Contact name: (other than recipient)		Phone:	
Relationship to recipient:			

4. Daily routine (Describe recipients' usual daily routine:

5. Assessment information		
Purpose of request ☐ Initial ☐ Annual Reassessment	Location: ☐ House ☐ Apartment ☐ Mobile Home ☐ Facility ☐ SLA (Supportive living arrangements) ☐ Other:	Information obtained from: ☐ Recipient ☐ Other:

6. Medical and Mental Health Diagnosis		
Diagnosis	Diagnosis	Diagnosis

7. Medications

Medication/dosage/frequency	Medication/dosage/frequency

8. Objective observations of functional ability including serious events over the past year

9. Assistive devices (check all that apply)

Equipment: H=Has U=Uses N=Needs

H U N		H U N		H U N	
☐ ☐ ☐	Lift/ Hoyer	☐ ☐ ☐	Walker	☐ ☐ ☐	Cane Crutches
☐ ☐ ☐	Commode	☐ ☐ ☐	Oxygen	☐ ☐ ☐	Power Chair
☐ ☐ ☐	Bath/Shower bench			☐ ☐ ☐	Hospital Bed
☐ ☐ ☐	Manual Chair	☐ ☐ ☐	slide board	☐ ☐ ☐	Other:
☐ ☐ ☐	Incontinent Supplies			☐ ☐ ☐	Other:
☐ ☐ ☐	Raised toilet Seat			☐ ☐ ☐	Other:
☐ ☐ ☐	Hand Held Shower				
☐ ☐ ☐	Nebulizer	☐ ☐ ☐	Glucometer		

10. Services: R=Receives N-Needs (check all that apply)

R N		R N	
☐ ☐	Aging and Disability Services	☐ ☐	Mental Health Services
☐ ☐	Audiology	☐ ☐	Home Health
☐ ☐	HCBW for Persons with Disabilities	☐ ☐	Dental
☐ ☐	Medical	☐ ☐	Home Delivered Meals
☐ ☐	IID Waiver	☐ ☐	Other:

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☐☐ Companion ☐☐ Respite ☐☐ Homemaker ☐☐ Chore ☐☐ Transportation ☐☐ PT/OT/ST ☐☐ Personal Emergency Response ☐☐ Ocular	☐ ADHC Attends days per week hours per day ☐ School Attends days per week hours per day ☐ Work Program Attends days per week hours per day ☐ Personal Care Services Provider days per week/hours
Comments:	

I, my Designated Representative or Legal Guardian participated in the assessment process, providing accurate information to the best of my/their ability.

Print Name (Recipient)	Signature	Date
Legal Guardian/Designated Representative	Signature	Date
Case Manager	Signature	Date
Provider	Signature	Date

Identify relationship of person signing this form.

☐ Self ☐ Legal Guardian/Designated Representative

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